DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 03 - 02

2. STATE: Virginia

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250 et. seq.

7. FEDERAL BUDGET IMPACT: $ (6,992,349)
a. FFY 2004 ~~$13,990,204~~
b. FFY _____ $ _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A, pp. 9, 13, 16 of 23.
Attachment 4.19 D, Supplement 1, p. 26 of 61

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same pages

10. SUBJECT OF AMENDMENT:
Inpatient Hospital Reimbursement Inflation and Capital Costs;
Freestanding Psychiatric Hospital Reimbursement; NF Inflation Limit

GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Secretary, Health & Human Resources

12. SIGNATURE OF STATE AGENCY OFFICIAL:
P W Finnerty

13. TYPED NAME:
Patrick W. Finnerty

14. TITLE:
Director

15. DATE SUBMITTED:
7/3/03

16. RETURN TO:

Dept. of Medical Assistance Services
600 East Broad Street, #1300
Richmond, VA 23219

ATTN: Reg. Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
JUL 22 2003

18. DATE APPROVED:
FEB 10 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL - 1 2003

20. SIGNATURE OF REGIONAL OFFICIAL:
Charlene Brown

21. TYPED NAME:
Charlene Brown

22. TITLE:
Deputy Director, CMSO

23. REMARKS:

result in an expenditure for outlier operating payments equal to 5.1% of total operating payments, including outlier operating payments, for DRG cases. The methodology described in subsection A of this section shall be applied to all base year DRG cases on an aggregate basis, and the amount of the outlier operating fixed loss threshold shall be calculated so as to exhaust the available pool for outlier operating payments.

12 VAC 30-70-270. Repealed.

12VAC30-70-271. Payment for capital costs.

A. Inpatient capital costs shall be determined on an allowable cost basis and settled at the hospital's fiscal year end. Allowable cost shall be determined following the methodology described in Supplement 3 (12 VAC 30-70-10 through 12 VAC 30-70-130). Capital costs of Type One hospitals shall continue to be settled at 100% of allowable cost. For services beginning July 1, 2003, capital costs of Type Two hospitals shall be settled at 80% of allowable cost. For hospitals with fiscal years that do not begin on July 1, 2003, inpatient capital costs for the fiscal year in progress on that date shall be apportioned between the time period before and the time period after that date based on the number of calendar months before and after that date. Capital costs apportioned before that date shall be settled at 100% of allowable cost, and those after at 80% of allowable cost.

B. The exception to the policy in subsection A of this section is that the hospital specific rate per day for services in freestanding psychiatric facilities licensed as hospitals, as determined in 12 VAC 30-70-321 B, shall be an all-inclusive payment for operating and capital costs. Effective July 1, 2003, the capital portion of the rate per day shall be based on 80% of the average capital cost per day of freestanding psychiatric facilities licensed as hospitals.

12 VAC 30-70-280. Repealed.

12 VAC 30-70-281. Payment for direct medical education costs.

A. Direct medical education costs of nursing schools and paramedical programs shall continue to be paid on an allowable cost basis. Payments for direct medical education costs shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end.

B. Final payment for these direct medical education (DMedEd) costs shall be the sum of the fee-for-service DMedEd payment and the managed care DMedEd payment. Fee-for-service DMedEd payment is the ratio of Medicaid inpatient costs to total allowable costs, times total DMedEd costs. Managed care DMedEd payment is equal to the managed care days times the ratio of fee-for-service DMedEd payments to fee-for-service days.

C. Effective with cost reporting periods beginning on or after July 1, 2002, direct Graduate Medical Education (GME) costs for interns and residents shall be reimbursed on a per-resident prospective basis, subject to cost settlement as outlined in subdivision E of this section.

D. The new methodology provides for the determination of a hospital-specific base period per-resident amount to initially be calculated from cost reports with fiscal years

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES

12 VAC 30-70-350. Repealed.

12 VAC 30-70-351. Updating rates for inflation.

Each July, the DRI-Virginia moving average values as compiled and published by DRI WEFA, INC. under contract with the department shall be used to update the base year standardized operating costs per case, as determined in 12 VAC 30-70-361, and the base year standardized operating costs per day, as determined in 12 VAC 30-70-371, to the midpoint of the upcoming state fiscal year. The most current table available prior to the effective date of the new rates shall be used to inflate base year amounts to the upcoming rate year. Thus, corrections made by DRI WEFA, INC. in the moving averages that were used to update rates for previous state fiscal years shall be automatically incorporated into the moving averages that are being used to update rates for the upcoming state fiscal year. In setting rates effective from July 1, 2003 through June 30, 2004, for Type Two hospitals, the moving average value that would normally be used to represent inflation occurring from the midpoint of SFY2003 to the midpoint of SFY2004, shall be replaced by a percentage calculated by DMAS to ensure that the resulting estimated increase in payments to hospitals, by Medicaid, does not exceed $10,863,375 in SFY2004. After June 30, 2004, the rate-setting basis will revert back to the DRI-Virginia moving average values used according to the previous methodology in effect prior to July 1, 2003.

12 VAC 30-70-360. Repealed.

12 VAC 30-70-361. Base year standardized operating costs per case.

A. For the purposes of calculating the base year standardized operating costs per case, base year claims data for all DRG cases, including outlier cases, shall be used. Base year claims data for per diem cases shall not be used. Separate base year standardized operating costs per case shall be calculated for Type One and Type Two hospitals. In calculating the base year standardized operating costs per case, a transfer case shall be counted as a fraction of a case based on the ratio of its length of stay to the arithmetic mean length of stay for cases assigned to the same DRG as the transfer case.

B. Using the data elements identified in subsection E of 12 VAC 30-70-221, the following methodology shall be used to calculate the base year standardized operating costs per case:

1. The operating costs for each DRG case shall be calculated by multiplying the hospital's total charges for the case by the hospital's operating cost-to-charge ratio, as defined in subsection C of 12 VAC 30-70-221.

2. The standardized operating costs for each DRG case shall be calculated as follows:

a. The operating costs shall be multiplied by the statewide average labor portion of operating costs, yielding the labor portion of operating costs. Hence, the nonlabor portion of operating costs shall constitute one minus the statewide average labor portion of operating costs times the operating costs.

b. The labor portion of operating costs shall be divided by the hospital's Medicare wage index, yielding the standardized labor portion of operating costs.

c. The standardized labor portion of operating costs shall be added to the nonlabor portion of operating costs, yielding standardized operating costs.

3. The case-mix neutral standardized operating costs for each DRG case shall be calculated by dividing the standardized operating costs for the case by the hospital's case-mix index.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

D. In calculating the DRG relative weights, a threshold of five cases shall be set as the minimum number of cases required to calculate a reasonable DRG relative weight. In those instances where there are five or fewer cases, the department's Medicaid claims data shall be supplemented with Medicaid claims data from another state or other available sources. The DRG relative weights calculated according to this methodology will result in an average case weight that is different from the average case weight before the supplemental claims data was added. Therefore, the DRG relative weights shall be normalized by an adjustment factor so that the average case weight after the supplemental claims data were added is equal to the average case weight before the supplemental claims data were added.

E. The DRG relative weights shall be used to calculate a case-mix index for each hospital. The case-mix index for a hospital is calculated by summing, across all DRGs, the product of the number of groupable cases in each DRG and the relative weight for each DRG and dividing this amount by the total number of groupable cases occurring at the hospital.

12 VAC 30-70-390. Repealed.

12 VAC 30-70-391. Recalibration and rebasing policy.

A. The department recognizes that claims experience or modifications in federal policies may require adjustment to the DRG payment system policies provided in this part. The state agency shall recalibrate (evaluate and adjust the DRG relative weights and hospital case-mix indices) and rebase (review and update the base year standardized operating costs per case and the base year standardized operating costs per day) the DRG payment system at least every three years. Recalibration and rebasing shall be done in consultation with the Medicaid Hospital Payment Policy Advisory Council noted in 12VAC30-70-490. When rebasing is carried out, if new rates are not calculated before their required effective date, hospitals required to file cost reports and freestanding psychiatric facilities licensed as hospitals shall be settled at the new rates, for discharges on and after the effective date of those rates, at the time the hospitals' cost reports for the year in which the rates become effective are settled.

B. Effective from July 1, 2003 through June 30, 2004, although most hospital rates will be based on the 2001 base year, rates for freestanding psychiatric facilities licensed as hospitals shall continue to be based on the 1998 base year. That is, the rebasing of rates effective in SFY2004, shall be effective for all hospitals except freestanding psychiatric facilities licensed as hospitals. Effective July 1, 2004, rates for freestanding psychiatric facilities licensed as hospitals, will be set pursuant to the applicable policy in this section.

Article 3.
Other Provisions for Payment of Inpatient Hospital Services.

12 VAC 30-70-400. Determination of per diem rates.

This section shall be applicable to only those claims for discharges prior to July 1, 1999. Each hospital's revised per diem rate or rates to be used during the transition period (SFY 1997 and SFY 1998) shall be based on the hospital's previous peer group ceiling or ceilings that were established under the provisions of 12 VAC 30-70-10 through 12 VAC 30-70-130, with the following adjustments:

1. All operating ceilings will be increased by the same proportion to effect an aggregate increase in reimbursement of $40 million in SFY 1997. This adjustment incorporates in per diem rates the systemwide aggregate value of payment that otherwise would be made through the payment adjustment fund. This adjustment will be calculated using estimated 1997 rates and 1994 days.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

rates before the sale.

I. Public notice. To comply with the requirements of § 1902(a)(28)(c) of the Social Security Act, DMAS shall make available to the public the data and methodology used in establishing Medicaid payment rates for nursing facilities. Copies may be obtained by request under the existing procedures of the Virginia Freedom of Information Act.

12VAC 30-90-41.1 Modifications to Nursing Facility Reimbursement Formula. Repealed.

12VAC30-90-41.2. Limits on Application of Inflation Factor to Indirect and Direct Care Costs.

A. Effective on and after July 1, 2003 and for only State Fiscal Year 2004 (ending June 30, 2004), the adjustment for inflation of nursing facility direct care rates and ceilings as referenced at 12VAC30-90-41.B above shall be calculated in a manner to ensure that the increase in payments does not exceed $8,768,125 in General Funds and $8,813,838 in Non-General Funds.

B. Effective on and after July 1, 2003 and for only State Fiscal Year 2004 (ending June 30, 2004), the adjustment for inflation of nursing facility indirect care rates and ceilings as referenced at 12VAC30-90-41.B above shall be calculated in a manner to ensure that the increase in payments does not exceed $2,325,094 in General Funds and $2,337,216 in Non-General Funds.

C. The provisions of this section 12VAC30-90-41.2 shall supersede, for the duration of July 1, 2003, through June 30, 2004, the applicable provisions in 12VAC30-90-41. The application of this section 12 VAC 30-90-41.2 shall end on June 30, 2004, and on July 1, 2004, the applicable provisions in 12 VAC 30-90-41 shall resume in effect.

12VAC30-90-42. Repealed.
12VAC30-90-43. Repealed.
12VAC30-90-44 to 12VAC30-90-49. Reserved.

Article 5
Allowable Cost Identification

12VAC30-90-50. Allowable costs.

A. Costs which are included in rate determination procedures and final settlement shall be only those allowable, reasonable costs which are acceptable under the Medicare principles of reimbursement, except as specifically modified in the Plan and as may be subject to individual or ceiling cost limitations and which are classified in accordance with the DMAS uniform chart of accounts (see 12VAC30-90-270).

B. Certification. The cost of meeting all certification standards for NF requirements as required by the appropriate state agencies, by state laws, or by federal legislation or regulations.